☐ **I would like to REGISTER for the conference**

☐ **I would like to submit an abstract**

## APPLICANT INFORMATION

Please fill in all the information, in BLOCK letters.

☐ **Dr.** ☐ **Mr.** ☐ **Ms.**

Name: First :

Middle:

Family:

Specialty/Job Title:

☐ Psychiatrist ☐ **Neurologist** ☐ **Surgeon**

☐ Psychologist ☐ **Internist** ☐ Social Worker

☐ Other _____

Department:

Place of work:

TEL (work): Area Code: No: Ext:

FAX:

Mobile: Area Code:

E-mail address

Mailing Address

ZIP / POSTAL CODE City:

Country:

## Payment Method

Please choose (√ ) the method of payment for your registration

☐ Cash ☐ Bank Transfer ☐ Cheque ☐ Visa ☐ MasterCard

## Registration Fee:

| | | |
|---|---|---|
| Individual Registration | Dhs 1250 | US$ 350 |
| Group Registration (>5) | Dhs 1100 | US$ 300 |